REQUEST FOR TRANSITIONAL MEDI-CAL (TMC) OR FOUR MONTH CONTINUING MEDI-CAL

Did your Medi-Cal or CalWORKS cash aid stop and:

- You or your family has earnings from a job, self-employment, or a pay raise? ❒ Yes ❒ No
- You or your family started receiving or had an increase in child/spousal support payments? ❒ Yes ❒ No

If you answered "YES" to either of these questions, you and other family members may still be eligible for Medi-Cal. Complete the form and attach your and your spouse's or other parent's most recent pay stubs or other proof of earnings. If you are self-employed, list business costs on a separate sheet of paper and attach proof of income and costs.

RETURN THIS REQUEST FORM TO YOUR COUNTY WORKER OR YOUR WELFARE OFFICE. DO *NOT* RETURN THIS FORM TO THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES.

Please type or print clearly.

Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:									
		DATE PAID:	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
			___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
		GROSS AMOUNT:	$	$	$	$	$
Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:									
		DATE PAID:	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
			___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
		GROSS AMOUNT:	$	$	$	$	$
Name / Employer/source	TOTAL HOURS WORKED IN REPORT MONTH:									
		DATE PAID:	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
			___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
		GROSS AMOUNT:	$	$	$	$	$

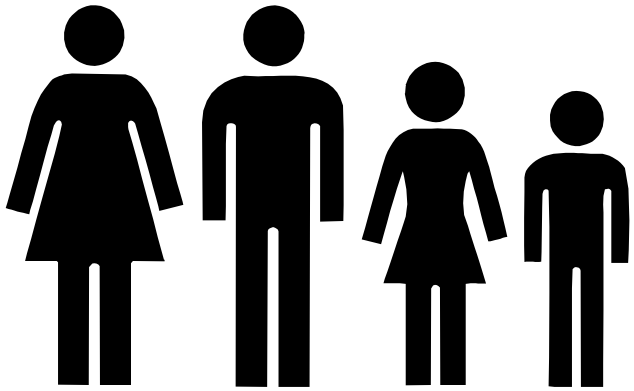
Did your family have any other changes, such as someone moved in or out of the house or was married, divorced, or became pregnant? ❒ Yes ❒ No If yes, please explain: _____

_____

I declare under penalty of perjury that all information provided is true and correct.

Name	Date of birth	Social security number
Signature ➤	County case number	Telephone number ( )
Address (number, street)	City	ZIP code
Signature of witness, interpreter, or person assisting ➤	Date	Telephone number ( )

TRANSITIONAL MEDI-CAL (TMC)



TMC May Provide You and Your Family with FREE Continued Medical Coverage For Up To 12 Months.

If you:

- ☛ **Get a job, or**
- ☛ **Get more money from your job, or**
- ☛ **Get child or spousal support,**

tell your worker right away or complete the back of this form and mail it to your worker. You may still be eligible for no-cost Medi-Cal. Your worker will determine whether your Medi-Cal health coverage can continue.

Health care is important for you and your family. Receiving Medi-Cal does not affect your CalWORKs time limits.

If you can't read this notice, ask your worker for a translation.

Spanish: **Si no puede leer esta notificación, pídale a su trabajador que se la traduzca.**

Cambodian: បើសិនជាលោកអ្នកមិនយល់សេចក្តីប្រកាសនេះទេ សូមសាកសួរអោកសេចក្តីបកប្រែពីអ្នកការន់សំណុំរឿងរបស់លោកអ្នក ។

Chinese: 假如你看不懂這份通知，可以要求你的工作員幫助你翻譯。

Russian: Если Вы не можете прочитать и (или) понять это извещение, попросите Вашего работника перевести.

Vietnamese: Nếu quý vị không biết tiếng Anh để hiểu nội dung thông báo này, hãy xin nhân viên phụ trách tìm người dịch giúp cho quý vị.